Compliments of the Author

OPERATION FOR PTOSIS.

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ILLUSTRATED.

In those slight cases of ptosis, either of the paralytic or congenital variety, in which the levator palpebrae still retains some of its power, the stitch operations of Pagenstecher or Dransart for raising the lid by sutures passed from the margin of the lid beneath the skin to the eyebrow,

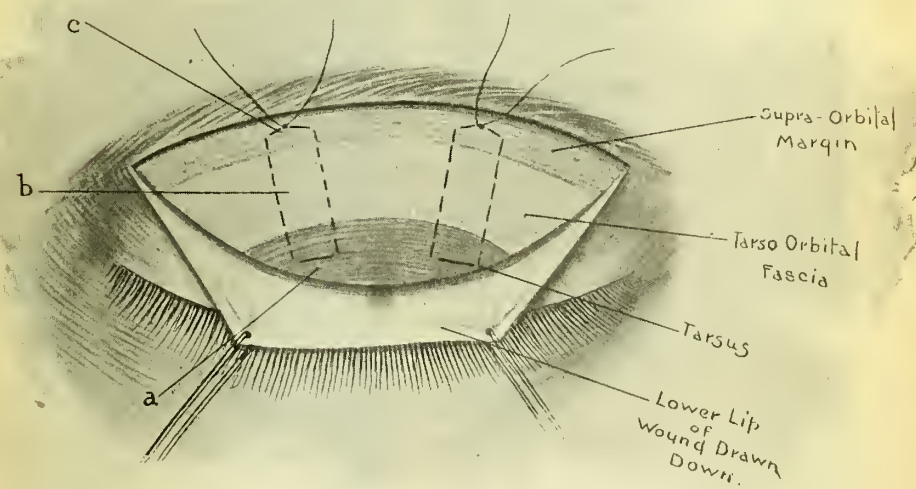

Fig. 1.

or the ingenious operation of Eversbusch for advancing the levator usually meet the requirements.

But in some cases of congenital ptosis it has been demonstrated that the levator of the lid is absent, and it is

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probably true that in most of them there is a faulty development of the muscle.

Again the muscle may be powerless because of an anomalous or defective development of its nerve center, illustrations of which we have in those peculiar cases of congenital ptosis in which the drooping lid can be raised only in association with certain movements of the jaw.

In complete paralytic ptosis we cannot reasonably expect to gain the desired correction of the deformity by advancing a muscle that is absolutely powerless and, at least in long standing cases, has suffered a partial atrophy.

In such cases the operation of Panas is largely practiced.

C. W. Age 15.
Congenital Ptosis of Right Lid.
Operated February, 1896.

C. W.
One year after the operation

The criticism justly urged against this valuable method is, that in fixing the rectangular lid flap beneath the bridge flap, a raw surface is opposed to a skin surface with the result that after healing a little pouch is formed beneath the eyebrow in which dirt may accumulate to cause subsequent trouble.

The ideal operation is that which will restore to the lid the power of opening and closing the palpebral fissure at will, but this from the very nature of many of the cases is impossible of attainment.

The result with which we must be satisfied, after most operations, is that in which the lid is held up so that the patient can use the eye and can also close it enough to give protection to the cornea, and this should be accomplished with the least possible deformity.

The operation here described which I have done in a number of cases accomplished this result fairly well. It is indicated particularly in those cases of congenital and paralytic ptosis, in which the power of the levator is completely lost.

It consists in folding upon itself the tarso-orbital fascia as well as the aponeurosis of the levator which is intimately adherent to the fascia; and at the same time in establishing a secure connection of the upper lid to the firm tissues above the eyebrow.

The tarso-orbital fascia extends from the margin of the orbit to the tarsus, separating the connective tissue of the lid from that of the orbital cavity. Being a layer of deep fascia, it is continuous with the periosteum, and the upper part of it acts as a suspensory ligament for the upper lid.

By shortening this ligament the lid may be raised as much as desired.

After shaving the eyebrow an incision is made a little above the orbital margin but parallel with it through all the tissues down to the periosteum.

This incision may be one inch and a half or even more in length, but should be so placed that the resulting scar will be concealed by the eyebrow.

A retractor being used to draw down the lower lip of the wound, the skin and muscle are separated from the fascia by careful dissection until the tarsus is brought into view. This is more easily accomplished if an assistant puts the lid on the stretch. Sutures of fine sterilized catgut or silk armed at each end with a curved needle are passed in the following manner. The first needle is introduced deep enough into the tarsus to secure a firm hold at a point about at the junction of the outer and middle third and a little distance from its convex edge (a). (See Fig.) It is then drawn through and with it several gathering stitches

(b) are taken in the tarso-orbital fascia, after which the needle is made to pass through the muscle and connective tissue of the upper lip of the wound (c).

The other needle on the same suture follows a parallel course in the same manner, entering the tarsus about 3 mm. from the point of entrance of the first, then gathering the fascia into small folds and emerging in the tissue above, thus making a loop by which the lid may be drawn up (c).

The second suture is passed in the same way making a

E. H. Aged 36. Complete Ptosis of Left Lid. Operated Aug. 29, 1894.

loop at the junction of the middle and inner third of the tarsus.

The requisite elevation of the lid may be now secured by drawing on the loops and tying the sutures, which are to be buried in the wound.

The lower lip of the wound is now united to the upper with fine sutures. The slight scar that remains after healing is almost entirely hidden when the eyebrows grow again.

The buried sutures become encapsuled and give additional strength to the folds of fascia that hold up the lid.

The orbicularis is uninjured so that the patient retains to a certain extent the power of closing the lids.

The oozing should be carefully checked before the wound is finally closed to prevent extravasation into the surrounding tissues and into the pouch formed by the dissection of the tissues from the fascia. Such a swelling may defeat the operation by causing the buried sutures to break their fastenings, before the folds of fascia have become firmly united to each other and to the margin of the orbit. To still further guard against such an accident and to give the lid temporary support until the deep parts have healed, the lid and the brow may be painted with collodion, or a small pad of cotton may be so placed in the dressing as to relieve undue traction on the sutures.

In one case upon which I operated, that of the boy whose picture is exhibited, suppuration followed because of some neglect or error in the antiseptic details, and an abscess developed in the upper lid which required drainage and irrigation, but this did not seem to impair the final result, although one of the buried sutures came away.

Within the last three and a half years I have practiced this operation, with a slight variation in detail, on thirteen cases, with sufficient degree of success to assure me that when properly done, it very satisfactorily corrects the deformity.

Most of the cases passed from my observation soon after they had recovered, and I am unable to speak of their present condition, but judging from those whose pictures I show I have reason to believe that the result is a permanent and satisfactory one.

It is true the number of cases is not large, but they show that complete ptosis may be relieved by shortening the suspensory ligament of the lid with buried sutures.

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